STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
201 W. Preston Street • Baltimore, Maryland 21201
Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

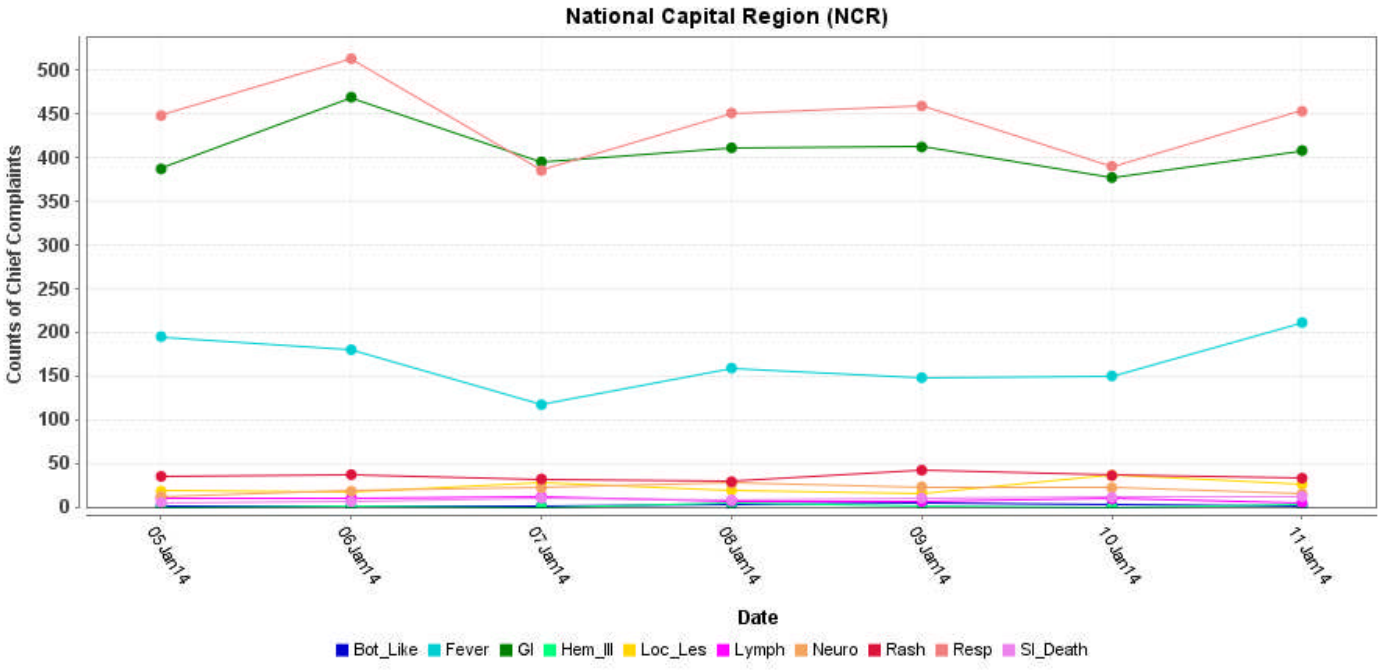
January 17, 2014

Public Health & Emergency Preparedness Bulletin: # 2014:02
Reporting for the week ending 01/11/14 (MMWR Week #02)

CURRENT HOMELAND SECURITY THREAT LEVELS

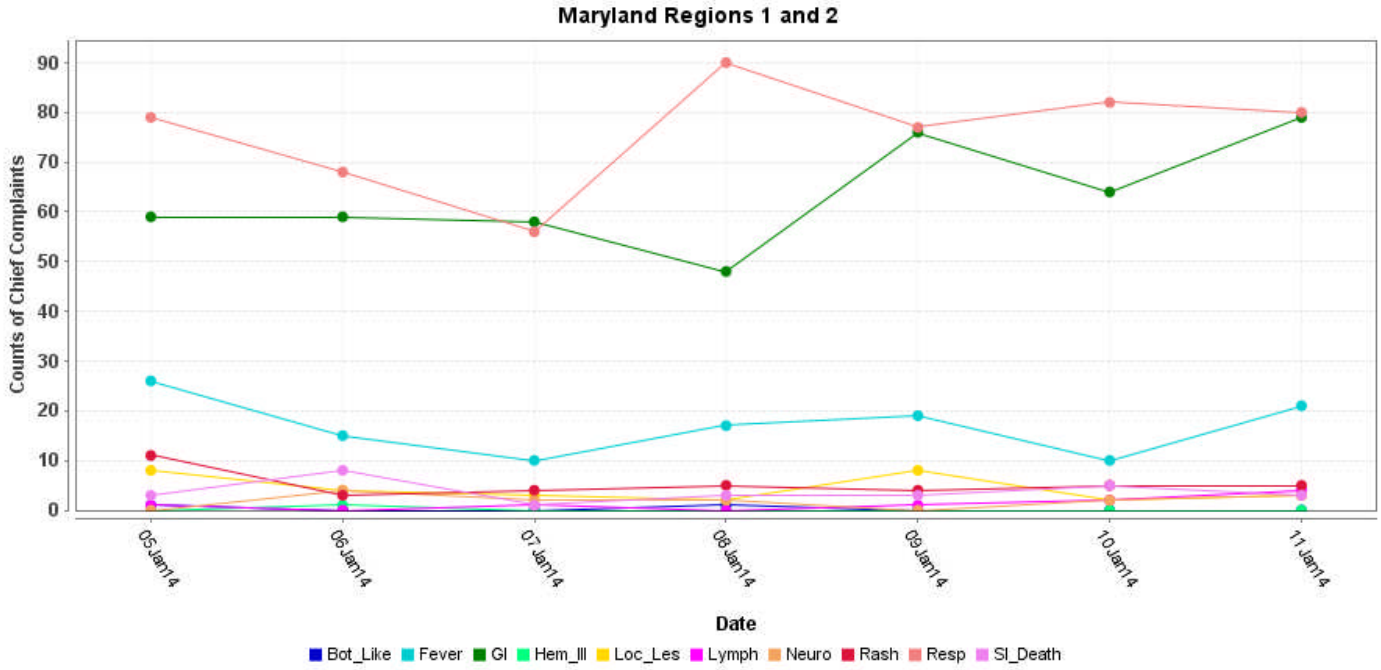
National: **No Active Alerts**
Maryland: **Level Four (MEMA status)**

SYNDROMIC SURVEILLANCE REPORTS
ESSENCE (Electronic Surveillance System for the Early Notification of Community-based Epidemics):
Graphical representation is provided for all syndromes, excluding the "Other" category, all age groups, and red alerts are circled. Red alerts are generated when observed count for a syndrome exceeds the 99% confidence interval. Note: ESSENCE – ANCR uses syndrome categories consistent with CDC definitions.
Overall, no suspicious patterns of illness were identified. Track backs to the health care facilities yielded no suspicious patterns of illness.

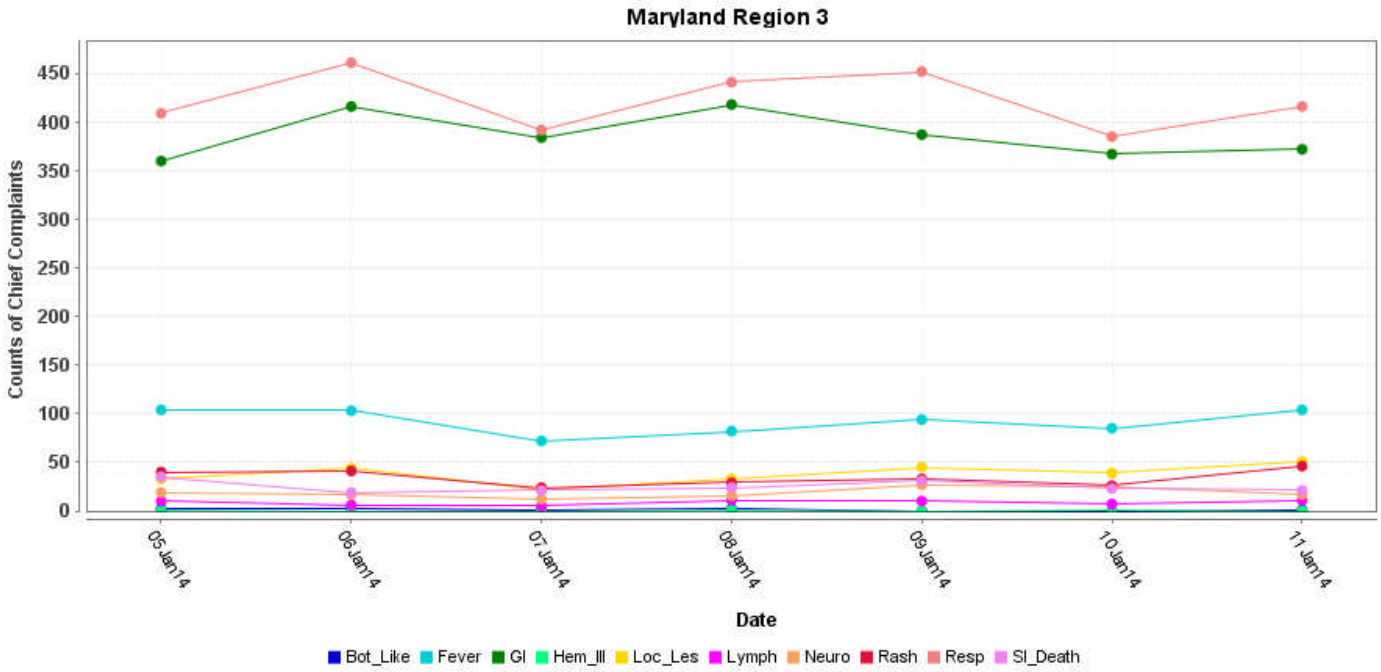


*Includes EDs in all jurisdictions in the NCR (MD, VA, and DC) reporting to ESSENCE

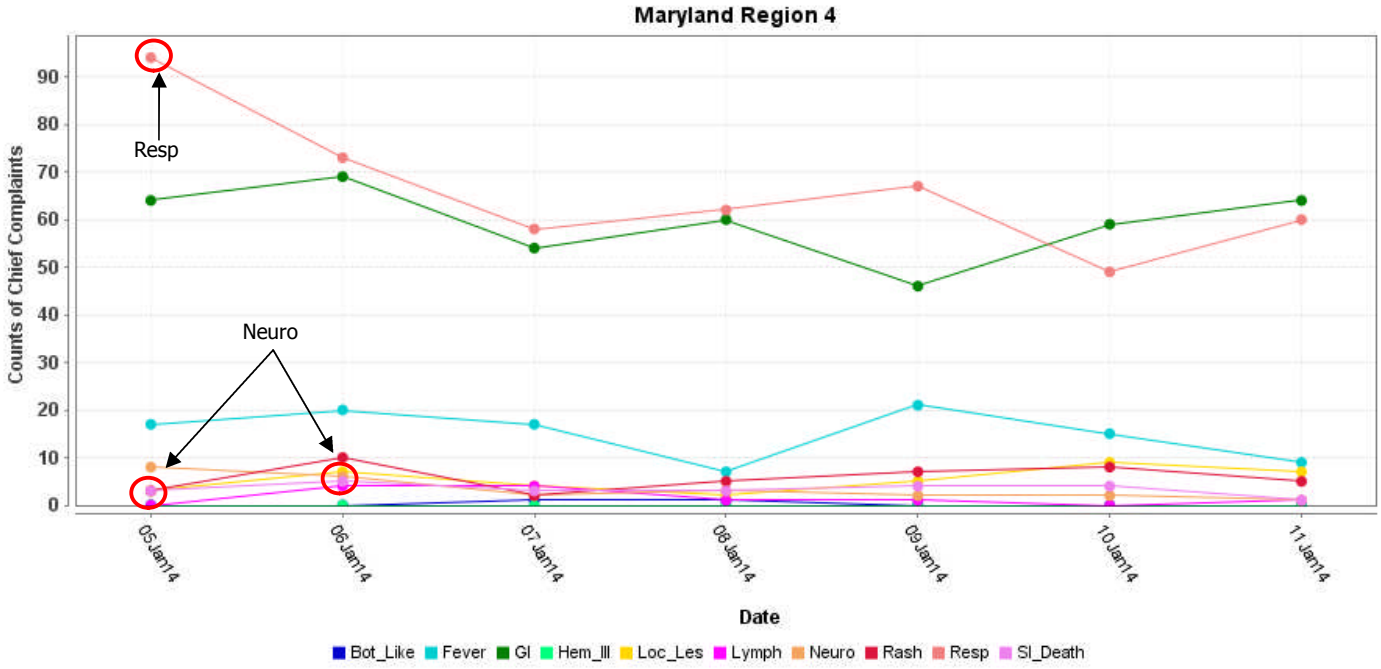
MARYLAND ESSENCE:



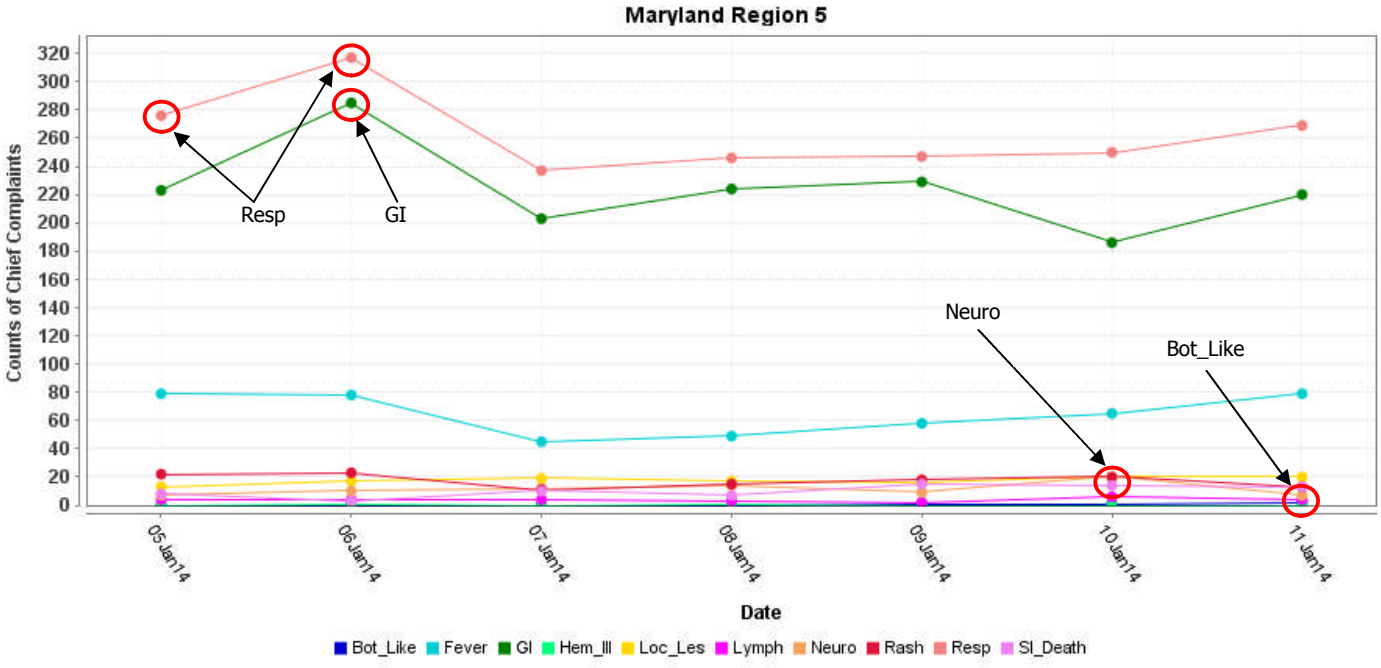
* Region 1 and 2 includes EDs in Allegany, Frederick, Garrett, and Washington counties reporting to ESSENCE



* Region 3 includes EDs in Anne Arundel, Baltimore City, Baltimore, Carroll, Harford, and Howard counties reporting to ESSENCE



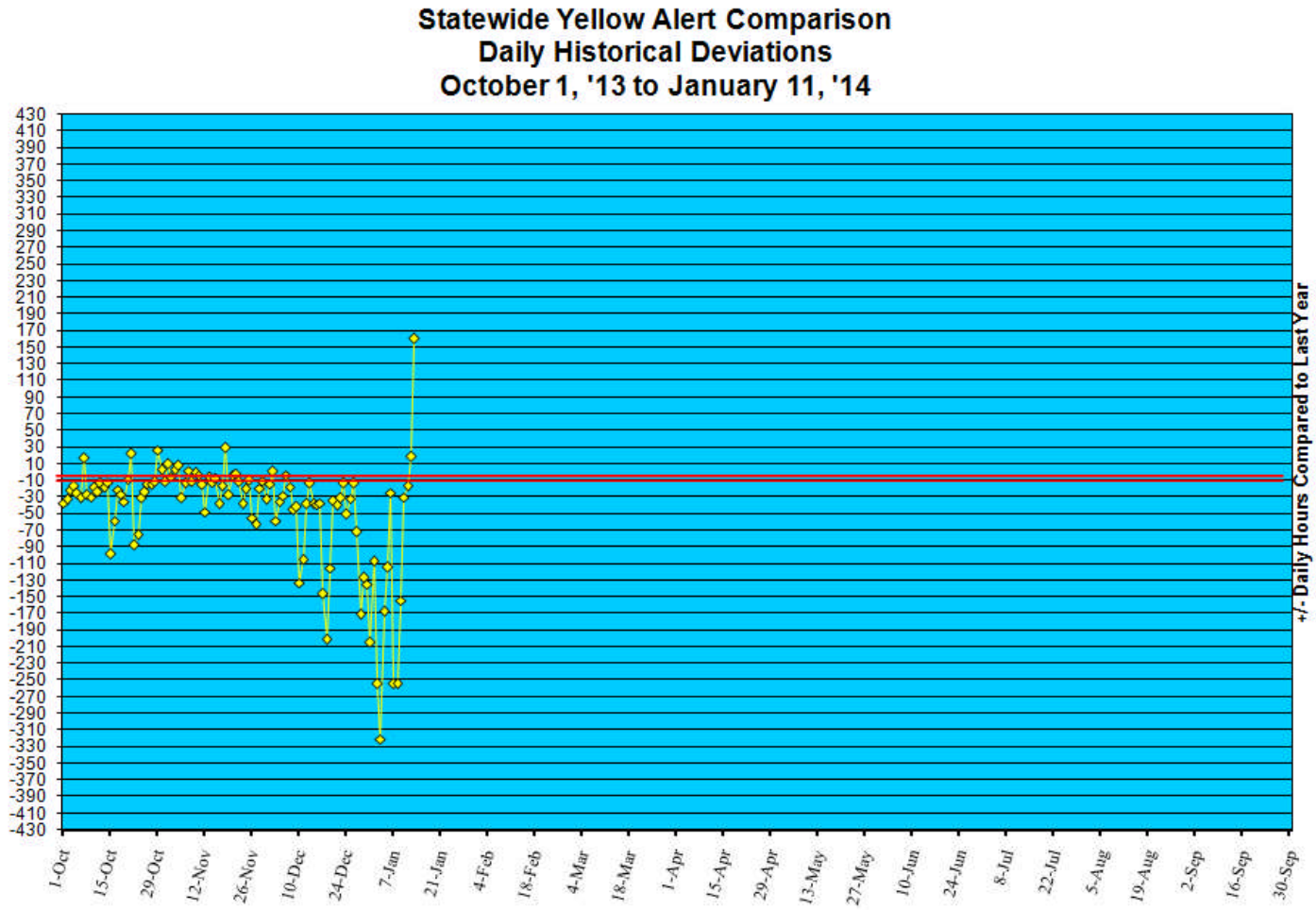
* Region 4 includes EDs in Cecil, Dorchester, Kent, Somerset, Talbot, Wicomico, and Worcester counties reporting to ESSENCE



* Region 5 includes EDs in Calvert, Charles, Montgomery, Prince George's, and St. Mary's counties reporting to ESSENCE

REVIEW OF EMERGENCY DEPARTMENT UTILIZATION

YELLOW ALERT TIMES (ED DIVERSION): The reporting period begins 10/01/13.



REVIEW OF MORTALITY REPORTS

Office of the Chief Medical Examiner: OCME reports no suspicious deaths related to an emerging public health threat for the week.

MARYLAND TOXIDROMIC SURVEILLANCE

Poison Control Surveillance Monthly Update: Investigations of the outliers and alerts observed by the Maryland Poison Center and National Capital Poison Center in December 2013 did not identify any cases of possible public health threats.

REVIEW OF MARYLAND DISEASE SURVEILLANCE FINDINGS

COMMUNICABLE DISEASE SURVEILLANCE CASE REPORTS (confirmed, probable and suspect):

Meningitis:	**Aseptic**	**Meningococcal**
New cases (January 5 - January 11, 2014):	14	0
Prior week (December 29, 2013 - January 4, 2014):	5	0
Week#02, 2013 (January 6 – January 12, 2013):	7	0

5 outbreaks were reported to DHMH during MMWR Week 02 (January 5 - 11, 2014)

3 Gastroenteritis Outbreaks
2 outbreaks of GASTROENTERITIS in Nursing Homes
1 outbreak of GASTROENTERITIS in an Assisted Living Facility

1 Foodborne Outbreak
1 outbreak of GASTROENTERITIS/FOODBORN associated with an Event Venue

1 Respiratory Illness Outbreak
1 outbreak of PNEUMONIA in a Nursing Home

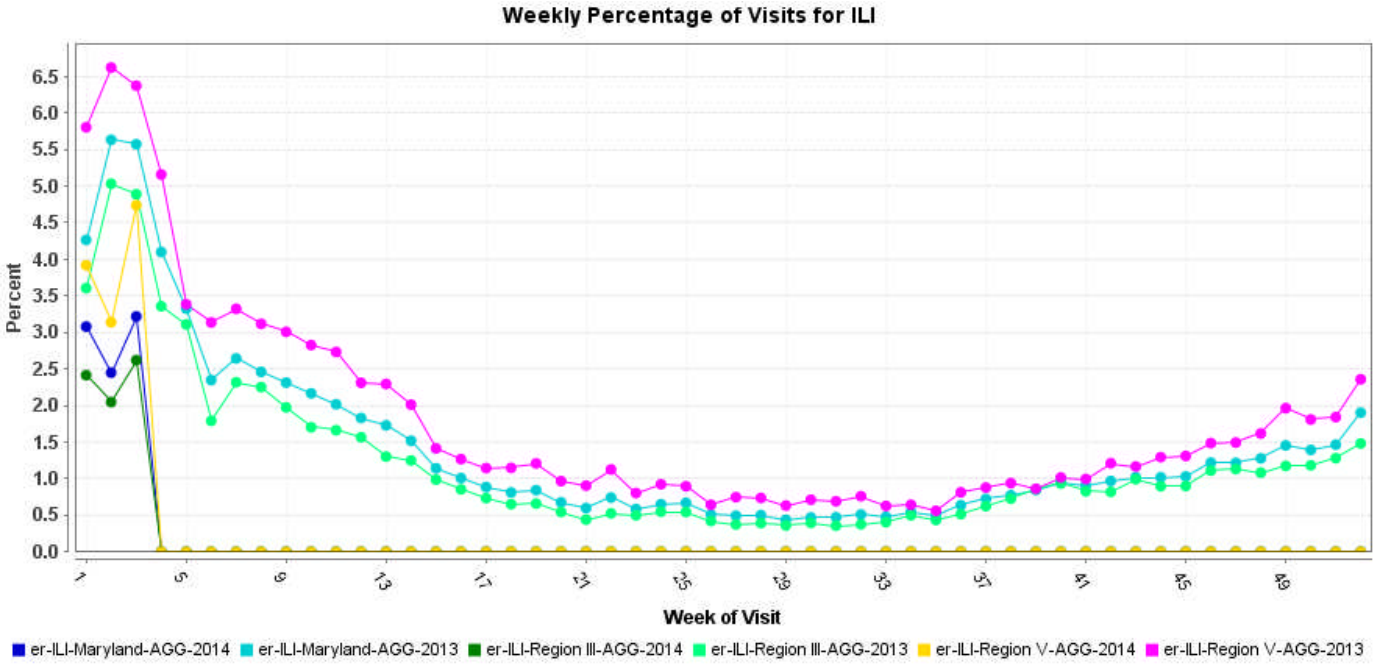
MARYLAND SEASONAL FLU STATUS

Seasonal Influenza reporting occurs October through May. Seasonal influenza activity for Week 02 was: Widespread with Minimal Intensity

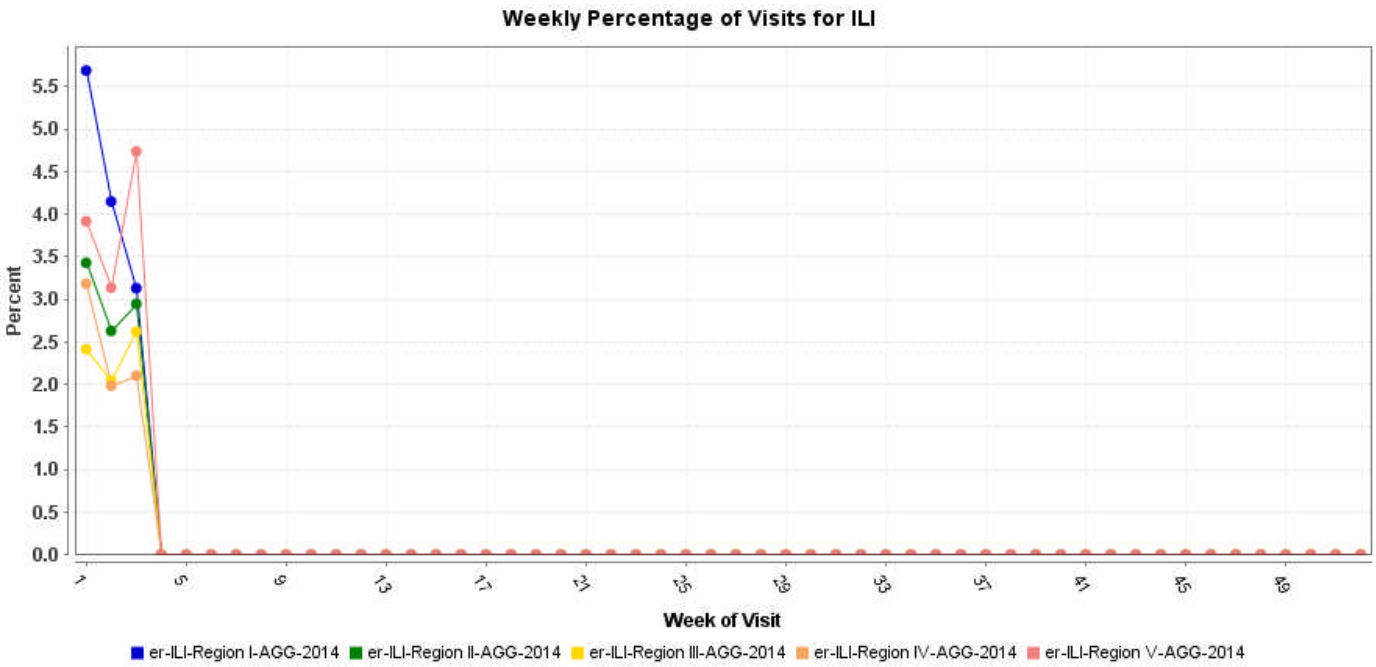
SYNDROMIC SURVEILLANCE FOR INFLUENZA-LIKE ILLNESS

Graphs show the percentage of total weekly Emergency Department patient chief complaints that have one or more ICD9 codes representing provider diagnoses of influenza-like illness. These graphs do not represent confirmed influenza.

Graphs show proportion of total weekly cases seen in a particular syndrome/subsyndrome over the total number of cases seen. Weeks run Sunday through Saturday and the last week shown may be artificially high or low depending on how much data is available for the week.



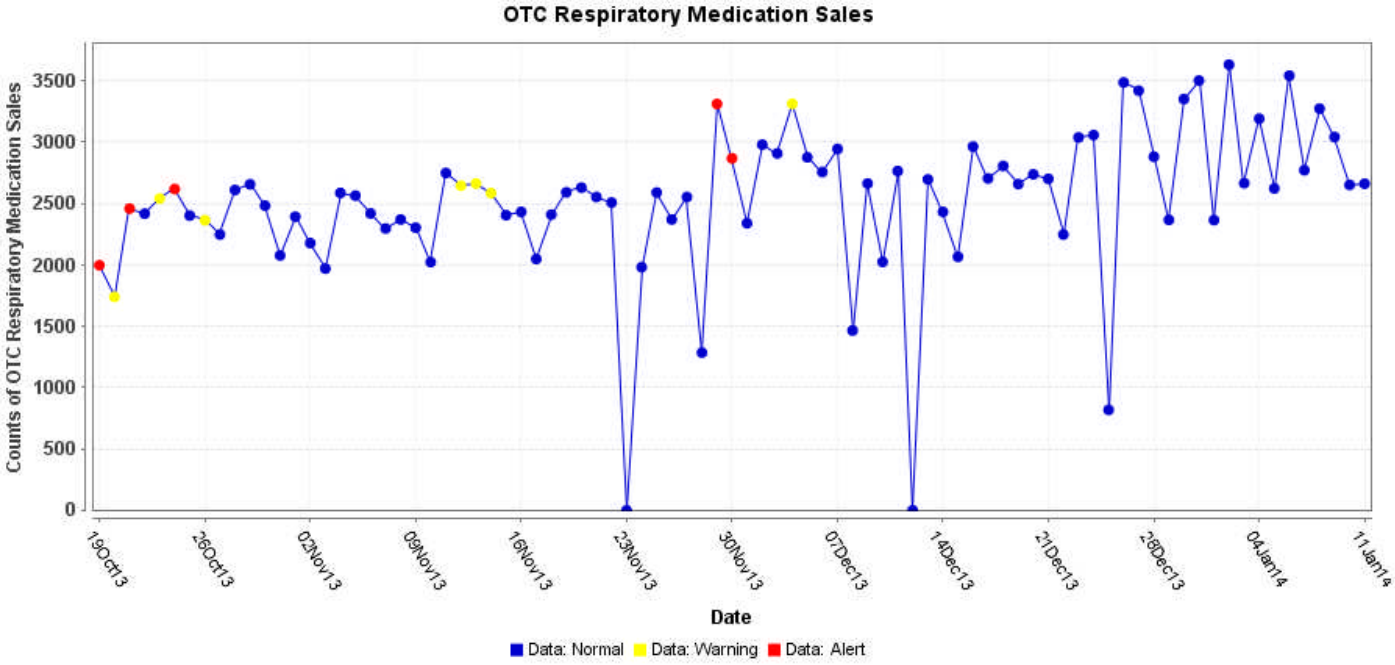
* Includes 2012 and 2013 Maryland ED visits for ILI in Metro Baltimore (Region 3), Maryland NCR (Region 5), and Maryland Total



*Includes 2013 Maryland ED visits for ILI in Region 1, 2, 3, 4, and 5

OVER-THE-COUNTER (OTC) SALES FOR RESPIRATORY MEDICATIONS:

Graph shows the daily number of over-the-counter respiratory medication sales in Maryland at a large pharmacy chain.



PANDEMIC INFLUENZA UPDATE / AVIAN INFLUENZA-RELATED REPORTS

WHO update: The current WHO phase of pandemic alert for avian influenza is ALERT. Currently, the avian influenza H5N1 virus continues to circulate in poultry in some countries, especially in Asia and northeast Africa. This virus continues to cause sporadic human infections with some instances of limited human-to-human transmission among very close contacts. There has been no sustained human-to-human or community-level transmission identified thus far.

Influenza A (H7N9) is one of a subgroup of influenza viruses that normally circulate among birds. Until recently, this virus had not been seen in people. However, human infections have now been detected. As yet, there is limited information about the scope of the disease the virus causes and about the source of exposure. The disease is of concern because most patients have been severely ill. There is no indication thus far that it can be transmitted between people, but both animal-to-human and human-to-human routes of transmission are being actively investigated.

Alert phase: This is the phase when influenza caused by a new subtype has been identified in humans. Increased vigilance and careful risk assessment, at local, national and global levels, are characteristic of this phase. If the risk assessments indicate that the new virus is not developing into a pandemic strain, a de-escalation of activities towards those in the interpandemic phase may occur. As of December 10, 2013, the WHO-confirmed global total of human cases of H5N1 avian influenza virus infection stands at 648, of which 384 have been fatal. Thus, the case fatality rate for human H5N1 is approximately 59%.

AVIAN INFLUENZA, HUMAN (H9N2): The steady pace of new H7N9 influenza infections in China continued today [10 Jan 2014] with reports of 6 more cases, one of them fatal, and the 1st notification of the year [2014] from Fujian province, the country's 4th to detect the novel virus over the past several weeks. Of the patients, 2 are from southern China's Guangdong province, which seems to be a hotspot of H7N9 activity, which started picking up again in October 2013 after a lull over the late spring and summer. In a related development today [10 Jan 2014], animal health officials in Guangdong reported more H7N9 findings from a restaurant and some live poultry markets, according to media reports. Details on the 6 new cases were reported today [10 Jan 2014] in 2 separate statements from Hong Kong's Centre for Health Protection (CHP). The patients from Guangdong are both from Foshan and are a 42-year-old woman who works with poultry and a 59-year-old woman. The 2 women have mild infections, according to a report from Xinhua, China's state news agency. Today's [10 Jan 2014] official notices and media reports contained no details about poultry exposure in the other new cases. Of the new patients, 2 are from Zhejiang province, a 30-year-old man and a 79-year-old woman, both of whom are in critical condition, according to the CHP. In a separate statement, the CHP said a 54-year-old man from the Jiangsu province city of Nanjing started having symptoms on 28 Dec [2013] and was hospitalized on 5 Jan [2014], where he is currently in serious condition. The latest death from the disease is related to a newly reported case from Fujian province, in a 38-year-old man from Quanzhou who had an underlying medical condition, according to the CHP. His infection is the 1st H7N9 case reported in Fujian since late April 2013. Meanwhile, the World Health Organization (WHO) today [10 Jan 2014] acknowledged that it had received reports of 2 other H7H9 [virus infection] cases that were detected over the past week, those involving a 65-year-old man reported on 8 Jan [2014] as Hong Kong's 3rd infection imported from the mainland and a 51-year-old woman from Zhejiang province, whose illness was 1st reported yesterday [9 Jan 2014]. Today's [10 Jan 2014] new H7N9 cases raise the unofficial total of infections in the outbreak to 163 and the death toll to 50; 15 cases have been reported since the 1st of the year [2014] by China and its close neighbors. In other developments, the H7N9 virus has been found in environmental samples from a restaurant and near wet markets in Guangdong, Want China Times, an English news web site based in Taiwan, reported today [10 Jan 2014]. The report cited Southcn.com, a Guangdong-based news web site. According to the report, 3 of 17 samples from a restaurant in Guangzhou tested positive for the virus. The report also said a recently confirmed H7N9 patient had delivered live chickens from Foshan to the eatery; 2 of the 3 samples were from poultry, and another was from a chopping board. Authorities have sterilized the restaurant and have found no illnesses among the restaurant staff. According to the story, 4 positive samples were also found in testing near Guangzhou wet markets in Zecheng and Zuhan districts. Also, 8 of 34 samples taken outside a wet market in the city of Shantou's Jinping district were positive for the virus, according to the Times report.

NATIONAL DISEASE REPORTS*

SALMONELLOSIS (TENNESSEE): 10 January 2013, Tyson Foods, Inc, a Sedalia, Missouri establishment, is recalling about 33 840 pounds [15.35 tons] of mechanically separated chicken products that may be contaminated with a *Salmonella Heidelberg* strain, the USA Department of Agriculture's Food Safety and Inspection Service (FSIS) announced today, 10 Jan 2014. The mechanically separated chicken products were produced on 11 Oct 2013. The following products are subject to recall: 40-lb cases, containing 4, 10-lb chubs of "Tyson Mechanically Separated Chicken" [a chub in this context is a plastic or other flexible package of meat, usually ground meat or luncheon meat]. The products subject to recall bear the establishment number "P-13556" inside the USDA mark of inspection with case code 2843SDL1412 - 18. These products were shipped for institutional use only, nationwide. The product is not available for consumer purchase in retail stores. FSIS was notified of a *S. Heidelberg* cluster of illnesses on 12 Dec 2013. Working in conjunction with the Tennessee Department of Health (TDH), FSIS determined that there is a link between the mechanically separated chicken products from Tyson Foods and the illness cluster in a Tennessee correctional facility. Based on epidemiological and traceback investigations, 7 case-patients at the facility have been identified with illnesses, with 2 resulting in hospitalization. Illness onset dates range from 29 Nov 2013 to 5 Dec 2013. FSIS continues to work with TDH on this investigation and will provide updated information as it becomes available. FSIS advises all consumers to safely prepare their raw meat products, including fresh and frozen, and only consume poultry products that has been cooked to a temperature of 165 deg F [74 deg C]. The only way to confirm that poultry products are cooked to a temperature high enough to kill harmful bacteria is to use a food thermometer that measures internal temperature. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *non-suspect case

ANTHRAX (MINNESOTA): 10 January 2014, Inhalation anthrax occurred in a man who vacationed in 4 US states where anthrax is enzootic. Despite an extensive multi-agency investigation, the specific source was not detected, and no additional related human or animal cases were found. Although rare, inhalation anthrax can occur naturally in the United States. Anthrax is a naturally occurring disease, affecting herbivores that ingest bacterial spores when consuming contaminated vegetation or soil. *Bacillus anthracis* spores are highly resistant to weather extremes and can remain viable in soil and contaminated animal products, such as bones or hides, for many years. Heavy rains or flooding can bring spores to the surface or concentrate organic material and spores in low-lying areas. As surface water evaporates, spores may attach to growing vegetation or become concentrated in soil around roots. Humans can become infected from exposure to infected animals or contaminated animal products (including meat, hides, and hair) or to contaminated dust associated with these products. Historically, inhalation anthrax was considered an occupational hazard for those working in wool and goat hair mills and tanneries. Recently, inhalation anthrax cases have resulted from exposure to African-style drums made of animal hides and from

bioterrorist attacks. State or local health departments, the Centers for Disease Control and Prevention (CDC), and the Federal Bureau of Investigation (FBI) undertake epidemiologic and criminal investigations whenever a clinical isolate is confirmed as *B. anthracis*. We did not find a specific exposure associated with anthrax infection for this case-patient and no other human or related animal cases. The clinical isolate genotype and sequence closely matched several previous environmental sample isolates from North America; however, no epidemiologic links were identified. The case-patient was exposed to airborne dust while traveling through areas where anthrax was enzootic; however, testing of vehicle air filters in which the dust was concentrated was negative for *B. anthracis* . Nonetheless, the patient may have been exposed through contact with an unidentified contaminated item. This investigation was limited by the poor sensitivity expected for soil sampling and lack of data to guide additional focused environmental sampling, precluding widespread random sample collection and testing along the route traveled. It is unusual for inhalation anthrax case-patients to have no identified exposure source. Inhalation of spore-contaminated soil has been suggested as a possible source of infection for bison in anthrax outbreaks in Canada. A heavy equipment operator acquired inhalation anthrax during a bison outbreak in Canada, where he dragged carcasses to burial sites and was exposed to airborne dust during operations. Chronic pulmonary disease or immuno-suppression may increase a person's susceptibility to inhalation anthrax. This case-patient had a decades-long history of chemical pneumonitis, and although he reported no respiratory difficulties, perhaps his risk was increased. He also had a history of mild diabetes; diabetes has been observed in other anthrax patients. This report highlights the challenges of investigating cases of anthrax when no specific suspected source exists. Anthrax, either naturally-occurring or bioterrorism-related, is a major public health concern, and timely recognition is critical. Clinicians and public health professionals should be cognizant that naturally acquired anthrax can occur in the United States and take appropriate steps to rapidly diagnose and investigate such cases. (Anthrax is listed in Category A on the CDC List of Critical Biological Agents) *non-suspect case

SALMONELLOSIS (USA): 11 January 2014, CDC is collaborating with public health officials in several states and the FDA to investigate a multistate outbreak of *Salmonella Stanley* infections. Results from this ongoing investigation indicate that raw cashew cheese produced by The Cultured Kitchen of West Sacramento, California is the likely source of this outbreak. Public health investigators are using DNA "fingerprints" of bacteria obtained through diagnostic testing with pulsed-field gel electrophoresis, or PFGE, to identify cases of illness that may be part of this outbreak. They are using data from PulseNet, the national subtyping network made up of state and local public health laboratories and federal food regulatory laboratories that performs molecular surveillance of foodborne infections. This strain of *Salmonella Stanley* is rare in the PulseNet database and has been seen only 20 times prior to this outbreak. A total of 14 ill persons infected with the outbreak strain of *S. Stanley* have been reported from 3 states. Most of the ill people have been reported from California (85 percent). The number of ill persons identified in each state is as follows: California (12), Nevada (1), and Wyoming (1); 1 ill person identified in Utah likely acquired their infection during international travel and was excluded from the case count. Among persons for whom information is available, illness onset dates range from 13 Nov 2013 to 9 Dec 2013. Ill persons range in age from 2 years to 77 years, with a median age of 27 years; 50 percent of ill persons are female. Among 12 ill persons with available information, 3 (25 percent) reported being hospitalized. No deaths have been reported. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *non-suspect case

INTERNATIONAL DISEASE REPORTS*

FOOD POISONING (JAPAN): 8 January 2014, Hundreds of people in Japan say they have fallen ill after eating frozen food that may have been contaminated with pesticide. Maruha Nichiro Holdings announced last week [week of 30 Dec 2013] that it was recalling products after some were found to contain high levels of malathion. The Health Ministry said at least 556 people had reported symptoms like diarrhea, vomiting and stomach pain. The pesticide is used in farming, gardening and for killing fleas. It was not immediately clear exactly how many people were affected. Public broadcaster NHK World on Wednesday [8 Jan 2014] said almost 900 people had reported symptoms after eating the products, which included pizza and chicken nuggets. Maruha, which has received hundreds of thousands of phone complaints, issued a public apology in newspapers on Wednesday. It is recalling at least 6.4 million food packages manufactured at a factory in Gunma prefecture, north of Tokyo. It started the food recall last week, recovering more than one million packages so far. "The products will have a strong smell, and eating them may cause vomiting and stomach pain," Maruha said in a notice to consumers. The cause of the contamination has not yet been determined. (Food Safety Threats are listed in Category B on the CDC List of Critical Biological Agents) *non-suspect case

ANTHRAX (ZIMBABWE): 9 January 2014, Recent outbreaks of typhoid and anthrax in Manicaland Province are now under control, a senior health official has said. Director of epidemiology and disease control in the Ministry of Health and Child Care Dr Portia Manangazira said in Makoni District, no anthrax related deaths were reported. She said 5 seriously ill people were still receiving treatment at Rusape General Hospital. [Originally, 6 were admitted. - Mod.MHJ] Dr Manangazira said a team from Harare, both from the health and agricultural sections, was working flat-out to control the outbreak. "We continue to ask for co-operation from the villagers to allow our officers to slaughter the affected animals. We also appeal to the villagers not to eat any products of an affected animal," Dr Manangazira said. So far, 27 people have been treated for anthrax after they ate meat from infected animals prior to the festive season. (Anthrax is listed in Category A on the CDC List of Critical Biological Agents) *non-suspect case

MERS-COV (OMAN): 9 January 2014, The case is a 59-year-old man who became sick with fever, cough, and shortness of breath on [20 Dec 2013] and was admitted to hospital in [Al Batinah North] Governorate on [24 Dec 2013]. On [28 Dec 2013] his condition deteriorated and he was transferred to an intensive care unit and was diagnosed with pneumonia. The patient died on [30 Dec 2013]. A laboratory confirmation of MERS-CoV was made on [1 Jan 2014]. The patient had a history of daily exposure to camels and other farm animals and also participated in camel race events. In addition, the man was a heavy smoker. Globally, from September 2012 to date, WHO has been informed of a total of 178 laboratory-confirmed cases of infection with MERS-CoV, including 75 deaths. Based on the current situation and available information, WHO encourages all Member States to continue their surveillance for severe acute respiratory infections (SARI) and to carefully review any unusual patterns. Health care providers are advised to maintain vigilance. Recent travelers returning from the Middle East who develop SARI should be tested for MERS-CoV as advised in the current surveillance recommendations. Patients diagnosed and reported to date have had respiratory disease as their primary illness. Diarrhea is commonly reported among the patients and severe complications include renal failure and acute respiratory distress syndrome (ARDS) with shock. It is possible that severely immunocompromised patients can present with atypical signs and symptoms. Health care facilities are reminded of the importance of systematic implementation of infection prevention and control (IPC). Health care facilities that provide care for patients suspected or confirmed with MERS-CoV infection should take appropriate measures to decrease the risk of transmission of the virus to other patients, health care workers, and visitors. All Member States are reminded to promptly assess and notify WHO of any new case of infection with MERS-CoV, along with information about potential exposures that may have resulted in infection and a description of the clinical course. Investigation into the source of exposure should promptly be initiated to identify the mode of exposure, so that further transmission of the virus can be prevented. People at high risk of severe disease due to MERS-CoV should avoid close contact with animals when visiting farms or barn areas where the virus is known to be potentially circulating. For the general public, when visiting a farm or a barn, general hygiene measures, such as regular hand washing before and after touching animals, avoiding contact with sick animals, and following food hygiene

practices, should be adhered to. WHO does not advise special screening at points of entry with regard to this event nor does it currently recommend the application of any travel or trade restrictions. WHO has convened an Emergency Committee under the International Health Regulations (IHR) to advise the Director-General on the status of the current situation. The Emergency Committee, which comprises international experts from all WHO Regions, unanimously advised that, with the information now available, and using a risk-assessment approach, the conditions for a Public Health Emergency of International Concern (PHEIC) have not at present been met. (Emerging Infectious Diseases are listed in Category C on the CDC List of Critical Biological Agents) *Non-suspect case

National and International Disease Reports are retrieved from http://www.promedmail.org/.

OTHER RESOURCES AND ARTICLES OF INTEREST

More information concerning Public Health and Emergency Preparedness can be found at the Office of Preparedness and Response website: http://preparedness.dhmh.maryland.gov/ or follow us on Facebook at www.facebook.com/MarylandOPR.

Maryland's Resident Influenza Tracking System: http://dhmh.maryland.gov/flusurvey

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NOTE: This weekly review is a compilation of data from various surveillance systems, interpreted with a focus on a potential BT event. It is not meant to be inclusive of all epidemiology data available, nor is it meant to imply that every activity reported is a definitive BT event. International reports of outbreaks due to organisms on the CDC Critical Biological Agent list will also be reported. While not "secure", please handle this information in a professional manner. Please feel free to distribute within your organization, as you feel appropriate, to other professional staff involved in emergency preparedness and infection control.

For questions about the content of this review or if you have received this and do not wish to receive these weekly notices, please e-mail us. If you have information that is pertinent to this notification process, please send it to us to be included in the routine report.

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Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents

Table: Text-based Syndrome Case Definitions and Associated Category A Conditions

Syndrome	Definition	Category A Condition
Botulism-like	ACUTE condition that may represent exposure to botulinum toxin ACUTE paralytic conditions consistent with botulism: cranial nerve VI (lateral rectus) palsy, ptosis, dilated pupils, decreased gag reflex, media rectus palsy. ACUTE descending motor paralysis (including muscles of respiration) ACUTE symptoms consistent with botulism: diplopia, dry mouth, dysphagia, difficulty focusing to a near point.	Botulism
Hemorrhagic Illness	SPECIFIC diagnosis of any virus that causes viral hemorrhagic fever (VHF): yellow fever, dengue, Rift Valley fever, Crimean-Congo HF, Kyasanur Forest disease, Omsk HF, Hantaan, Junin, Machupo, Lassa, Marburg, Ebola ACUTE condition with multiple organ involvement that may be consistent with exposure to any virus that causes VHF ACUTE blood abnormalities consistent with VHF: leukopenia, neutropenia, thrombocytopenia, decreased clotting factors, albuminuria	VHF
Lymphadenitis	ACUTE regional lymph node swelling and/ or infection (painful bubo- particularly in groin, axilla or neck)	Plague (Bubonic)
Localized Cutaneous Lesion	SPECIFIC diagnosis of localized cutaneous lesion/ ulcer consistent with cutaneous anthrax or tularemia ACUTE localized edema and/ or cutaneous lesion/ vesicle, ulcer, eschar that may be consistent with cutaneous anthrax or tularemia INCLUDES insect bites EXCLUDES any lesion disseminated over the body or generalized rash EXCLUDES diabetic ulcer and ulcer associated with peripheral vascular disease	Anthrax (cutaneous) Tularemia
Gastrointestinal	ACUTE infection of the upper and/ or lower gastrointestinal (GI) tract SPECIFIC diagnosis of acute GI distress such as Salmonella gastroenteritis ACUTE non-specific symptoms of GI distress such as nausea, vomiting, or diarrhea EXCLUDES any chronic conditions such as inflammatory bowel syndrome	Anthrax (gastrointestinal)

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents
(continued from previous page)

Syndrome	Definition	Category A Condition
Respiratory	ACUTE infection of the upper and/ or lower respiratory tract (from the oropharynx to the lungs, includes otitis media) SPECIFIC diagnosis of acute respiratory tract infection (RTI) such as pneumonia due to parainfluenza virus ACUTE non-specific diagnosis of RTI such as sinusitis, pharyngitis, laryngitis ACUTE non-specific symptoms of RTI such as cough, stridor, shortness of breath, throat pain EXCLUDES chronic conditions such as chronic bronchitis, asthma without acute exacerbation, chronic sinusitis, allergic conditions (Note: INCLUDE *acute exacerbation* of chronic illnesses.)	Anthrax (inhalational) Tularemia Plague (pneumonic)
Neurological	ACUTE neurological infection of the central nervous system (CNS) SPECIFIC diagnosis of acute CNS infection such as pneumoccocal meningitis, viral encephailitis ACUTE non-specific diagnosis of CNS infection such as meningitis not otherwise specified (NOS), encephailitis NOS, encephalopathy NOS ACUTE non-specific symptoms of CNS infection such as meningismus, delerium EXCLUDES any chronic, hereditary or degenerative conditions of the CNS such as obstructive hydrocephalus, Parkinson's, Alzheimer's	Not applicable
Rash	ACUTE condition that may present as consistent with smallpox (macules, papules, vesicles predominantly of face/arms/legs) SPECIFIC diagnosis of acute rash such as chicken pox in person > XX years of age (base age cut-off on data interpretation) or smallpox ACUTE non-specific diagnosis of rash compatible with infectious disease, such as viral exanthem EXCLUDES allergic or inflammatory skin conditions such as contact or seborrheaic dermatitis, rosacea EXCLUDES rash NOS, rash due to poison ivy, sunburn, and eczema	Smallpox
Specific Infection	ACUTE infection of known cause not covered in other syndrome groups, usually has more generalized symptoms (i.e., not just respiratory or gastrointestinal) INCLUDES septicemia from known bacteria INCLUDES other febrile illnesses such as scarlet fever	Not applicable

Syndrome Definitions for Diseases Associated with Critical Bioterrorism-associated Agents (continued from previous page)

Syndrome	Definition	Category A Condition
Fever	ACUTE potentially febrile illness of origin not specified INCLUDES fever and septicemia not otherwise specified INCLUDES unspecified viral illness even though unknown if fever is present EXCLUDE entry in this syndrome category if more specific diagnostic code is present allowing same patient visit to be categorized as respiratory, neurological or gastrointestinal illness syndrome	Not applicable
Severe Illness or Death potentially due to infectious disease	ACUTE onset of shock or coma from potentially infectious causes EXCLUDES shock from trauma INCLUDES SUDDEN death, death in emergency room, intrauterine deaths, fetal death, spontaneous abortion, and still births EXCLUDES induced fetal abortions, deaths of unknown cause, and unattended deaths	Not applicable